

Regional Support Team Referral

(To be completed by SC/CM if any of the following criteria are met)

RST referrals are required when any of the following are true. Mark only one reason and forward to the assigned Community Resource Consultant through IDOLS or secure email:

For individuals with I/DD **in the community** the following referral reason is primary:

- ☐ a. Difficulty finding services in the community within 3 months of receiving a slot.
- ☐ b. Moving to a group home of five or more individuals.
- ☐ c. Moving to a nursing home or ICF.
- ☐ d. Pattern of repeatedly being removed from home.

For individuals with I/DD **in training centers**:

- ☐ a. Moving to a nursing home, ICF-IID or group home with five or more individuals.
 - ☐ b. Difficulty finding particular type of community supports within 45 days of discharge plan.
 - ☐ c. PST cannot agree on a discharge plan outcome within 15 days of the annual PST meeting, or within 30 days after the admission to the Training Center.
 - ☐ d-1. Individual or AR opposes moving despite PST recommendation.
 - ☐ d-2. Individual or AR refuses to participate in the discharge planning process.
 - ☐ e. Hasn't moved within three months of selecting a provider (requires identifying the barriers to discharge and notifying the facility director and the CIM).
 - ☐ f. Recommended to remain in a Training Center (requires PST/CIM assessment at 90-day intervals).
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Individual's Unique ID: [Click here to enter unique ID.](#) **Individual's age:** [Click here to enter age.](#)

Date of referral: [Click here to enter a date.](#)

Submitter: [Click here to enter submitter name.](#) **Agency:** [Click here to enter submitter agency.](#)

Contact phone number: [Click here to enter phone number.](#)

Contact email: [Click here to enter email address.](#)

Reason for referral

1. Provide any information you think may be helpful in the RST review process [Click here to describe.](#)
2. If the individual or substitute decision-maker is choosing a **less integrated setting** (5 or more bed group home, community ICF-IID, Nursing Facility, Training Center, describe the reason(s) this setting is being selected: [Click here to describe reasons for selecting less integrated setting.](#)
 - [If this decision is being made by a substitute decision-maker, is the individual in agreement?](#) [Choose an item.](#)
3. What are the individual's **primary diagnoses** (DD, ID, autism, medical, psychiatric, etc)? [Click here to list.](#)

<u>Completed by SC/CM initially</u>		<u>Completed by Community Resource Coordinator/Community Integration Manager</u>		<u>Completed by SC/CM after recommendations received</u>
<u>Identified Barrier(s) (check all that apply)</u>	<u>Describe barrier(s) and what has been done to address them</u>	<u>CRC/CIM recommended actions</u>	<u>RST recommended actions</u>	<u>Describe additional actions taken and results</u>
<input type="checkbox"/> Unavailable in desired location				
<input type="checkbox"/> Lack of medical expertise				
<input type="checkbox"/> Lack of behavioral expertise				
<input type="checkbox"/> Lack of mental health expertise				
<input type="checkbox"/> Inability to obtain or use equipment in new environment				
<input type="checkbox"/> Lack of financial resources				
<input type="checkbox"/> Other barrier(s)				

Individual/Substitute Decision Maker final service decision(s)

4. Communicate back to CRC **after** CRC/CIM/RST recommendations are made and the move occurs:

RST recommendations followed: [Choose one.](#)

Final residential setting: [Choose an item.](#)

Final employment setting: [Choose an item.](#)

Final day/alternative setting: [Choose an item.](#)

Comments: [Click here to enter comments.](#)